City of Springfield Group Health Plan
Enrollment Application

Please write legibly in black or blue ink. Complete all applicable sections.

Group Policy No.	Subgroup/Class No:	AFSCME	IAFF	Non-Rep	SEIU/OPEU	SPA
G0020720	**HIP**: Active	☐P001-1101	☐P006-1201	☐P006-1301	☐P006-1401	☐P001-1501
	Retiree	☐P004-7101	☐P004-7201	☐P004-7301	☐P004-7401	☐P004-7501
	COBRA	☐P005-9101	☐P005-9201	☐P005-9301	☐P005-9401	☐P005-9501
	PPO: Active	☐P002-1102	☐P006-1202	☐P006-1302	☐P006-1402	☐P002-1502
	Retiree	☐P004-7102	☐P004-7202	☐P004-7302	☐P004-7402	☐P004-7502
	COBRA	☐P005-9102	☐P005-9202	☐P005-9302	☐P005-9402	☐P005-9502

Section 1 – Enrollment Information

Employer/Group Name	Effective Date
City of Springfield	month_____ day_____ year_____

Date of Full Time Hire (required)	Number of Hours Worked Per Week	Employment Status
month_____ day_____ year_____		☐Active ☐Other

Section 2 – Employee Information

Employee Last Name	First Name	M.I.

Mailing Address	City	State	Zip code

Home Phone No.	E-Mail Address	Job Title

Gender ☐Male ☐Female

Marital Status ☐Married ☐Single ☐Domestic Partner–If domestic partner, are you registered with the State of Oregon? ☐Yes ☐No

Are you an active employee? ☐Yes ☐No If yes, complete Section 2A. If no, complete Section 2B.

Section 2A – Type of New Enrollment

I am ☐New Employee ☐Adding dependent spouse, partner, or child

Date of qualifying event:_____ *Attach proof of event*

Event: ☐New Hire ☐Marriage ☐Domestic Registration
☐Birth ☐Adoption ☐Court Order
☐Involuntary loss of other group coverage
☐Late Enrollment or Open Enrollment *(see disclosure for information)*

Section 2B – Continuation of Coverage

I am eligible for ☐COBRA ☐State Continuation

Date of qualifying event:_____

Event: ☐Termination of employment or reduced hours
☐Divorce or legal separation
☐Dependent no longer meets eligibility
☐Death of a covered employee

Section 3 – Employee and Family Members You Wish to Enroll

***Race / Ethnicity** (choose the code each family member would most closely identify with)**:** **A**-American Indian/Alaska Native, **B**-Asian, **C**-Black/African American, **D**-Hispanic/Latino, **E**-Native Hawaiian/Other Pacific Islander, **F**-White/Caucasian

Name	*Sex*	*Birth Date*	*Social Security Number* ***(Required–refer to disclosure)***	**Race / Ethnicity*
Employee				
Spouse or Domestic Partner				
Dependent Child				
Dependent Child				
Dependent Child				
Dependent Child				
Dependent Child				

If you or your spouse/domestic partner are a court-ordered guardian of any dependent listed above, identify and provide proof:

Name(s):_____ Type: ☐Grandchild ☐Niece/Nephew ☐Sibling ☐Other_____

Primary language spoken in household: ☐English ☐Español ☐Other:

Para asistirle en español, por favor llame al numero (800) 624-6052, ext. 1009, de Lunes a Viernes, 7:00 a.m. hasta 5:00 p.m

Section 4 – Other Coverage

Current or Prior Coverage Information – Do you or any person listed on this application have or have had health insurance in the last 24 months? ☐No ☐Yes If yes, complete the following **and** attach proof with dates of coverage.

Name(s)	Insurance Carrier	Date of coverage	Will Coverage Continue?	Type of Coverage
	Carrier Name: Policy No.: Phone No.:	Begin: End:	☐Yes ☐No	☐Medical ☐Dental ☐Vision ☐Retiree
	Carrier Name: Policy No.: Phone No.:	Begin: End:	☐Yes ☐No	☐Medical ☐Dental ☐Vision ☐Retiree
	Carrier Name: Policy No.: Phone No.:	Begin: End:	☐Yes ☐No	☐Medical ☐Dental ☐Vision ☐Retiree

Married or partner – Is your spouse or domestic partner employed? ☐No ☐Yes If yes, self employed? ☐No ☐Yes

Medicare – If you or any person on this application has Medicare, is coverage? ☐Part A ☐Part B ☐Part D

Name	Original Effective Date	Medicare No. (include alpha prefix)	Reason for Medicare Entitlement
			☐Age ☐ESRD ☐Disability ☐Dual Entitlement
			☐Age ☐ESRD ☐Disability ☐Dual Entitlement

Section 5 – Child Custody Information

If you are enrolling children of a previous relationship, you must complete this section. List court ordered coverage in Section 4 above. Oregon law requires PacificSource to provide plan information to the custodial parent.

Child's Name	Whose Child	Joint Custody	Custodial Parent Name	Custodial Parent Address	Custodial Parent Phone No.	If Court Order, Name Responsible for Insurance
	☐Yours ☐Spouse	☐Yes ☐No				
	☐Yours ☐Spouse	☐Yes ☐No				
	☐Yours ☐Spouse	☐Yes ☐No				

Section 6 – Acknowledgement and Declaration

I acknowledge and understand that my Plan Sponsor or Plan Administrator may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on this enrollment form) from time to time for the purpose of facilitating health care treatment, payment, or for business operations necessary to administer health care benefits; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist, or other physical or behavioral healthcare practitioner;
- A clinic, hospital, long term care, or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or:
- An insurance carrier or group health plan.

Health or dental information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for this information.

I affirm that the answers given in this application are complete and correct.

Employee Signature **Date**

City of Springfield Group Health Plan Enrollment Application

Detach and keep for your records.

This enrollment application contains two parts: the enrollment form (pages 1–2) and information (page 3)

- **Please read the information pages carefully** to help you understand requirements of your employer's health plan.
- **Complete the enrollment form.** Be sure to answer everything that applies to you.
- **Sign and date the form.**
- **Detach the information pages and make a copy of the form.** Keep these pages with your own insurance records.
- **Return the original, completed form to your employer**.

Employee and Family Members You Wish to Enroll – Guidelines for Section 3

Social Security Numbers – A Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plans to report information the Secretary of the Department of Health and Human Services requires for coordination of benefits. To coordinate Medicare payments with other insurance benefits properly, they rely on both the Social Security Number (or Medicare Health Insurance Claim Numbers) and the Employer Identification Number. Please provide Social Security Numbers for each family member listed.

Dependents – Dependents of a covered employee who meet one of the following requirements are also eligible for enrollment.

- *Spouse.* The employee's lawfully married spouse.
- *Domestic partner.* The employee's same gender domestic partner who is registered with the State or Oregon or by affidavit.
- *Dependent child.* Any natural child, stepchild, or adopted child of employee, spouse, or domestic partner under age 26 regardless of the child's place of residence, marital status, or financial dependence on the employee.
- *Disabled dependent child.* A disabled child of any age who is unmarried; not in a domestic partnership, registered or otherwise; is otherwise eligible; and has been continuously incapable of self-sustaining employment since turning age 26 because of a mental disability or physical handicap. Documentation from the child's attending physician attesting to the incapacity and a review of the child's functional status by PacificSource is required.
- *Dependent family member.* A brother, sister, niece, nephew, or grandchild under 19 years of age who is unmarried; not in a domestic partnership, registered or otherwise; and the employee is designated by a court as legal guardian with the expectation that the dependent family member will live in the employee's household at least one year.

No other family or household members are eligible for coverage unless this contract is amended to specify otherwise.

Special Enrollment Rights

Special Enrollment Periods – Both you and your family members may decline this health coverage during your initial enrollment period. If you are eligible to decline coverage and wish to do so, you must submit a written waiver of coverage to PacificSource through your employer. You and your family members may enroll in this plan later if you qualify under Rule #1, #2, #3, or #4 below.

- *Special Enrollment Rule #1* – If you declined enrollment for yourself or your family members because of other health insurance coverage, you or your family members may enroll in the plan later if other coverage ends involuntarily. "Involuntarily" means coverage ended because continuation coverage was exhausted, employment terminated, the number of hours of employment were reduced below the employer's minimum requirement, the other insurance plan was discontinued or the maximum lifetime benefit of the other plan was exhausted, the employer's premium contributions toward the other insurance plan ended, or because of death of a spouse, divorce, or legal separation. You must request enrollment within 31 days after the other health insurance coverage ends (or within 60 days after the other health insurance coverage ends if the other coverage is through Medicaid or a State Children's Health Insurance Program). Coverage will begin on the first day of the month after the other coverage ends.

- *Special Enrollment Rule #2* – If you acquire new dependents because of marriage, domestic partnership, birth, or placement for adoption, you may be able to enroll yourself and/or your newly acquired dependents at that time. You must request enrollment within 31 days after the marriage, registration of the domestic partnership, birth, or placement for adoption. In the case of marriage and domestic partnership, coverage begins on the first day of the month after the marriage or registration of the domestic partnership. In the case of birth or placement for adoption, coverage begins on the date of birth or placement.

- *Special Enrollment Rule #3* – If you or your dependents become eligible for a premium assistance subsidy under Medicaid or a State Children's Health Insurance Program, you may be able to enroll yourself and/or your dependents at that time. To do so, you must request enrollment within 60 days of the date you and/or your dependents become eligible for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.

- *Special Enrollment Rule #4* – Part-time employees who have declined coverage may enroll if they move to full-time status by submitting an enrollment application within 31 days of the change. Coverage is effective the first of the month following the status change. Full-time employees must enroll during their initial enrollment period.

Late Enrollee – A "late enrollee" is an otherwise eligible employee or dependent who does not qualify for a special enrollment period, and who: did not enroll during the 31-day initial enrollment period; or enrolled during the initial enrollment period but discontinued coverage later. A late enrollee may enroll by submitting an enrollment application to your employer during your open enrollment period. When you or your dependents enroll during the open enrollment period, plan coverage begins on the plan's anniversary date.

Waiving Coverage

You and your family members may decline coverage when you are first eligible. To decline coverage, complete a **Waiver of Coverage form** instead of this form. For more information on your plan's special enrollment provisions, please contact your employer.

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Enrollment Application and Change of Information Form

Enrolled online _____ Date _____

* Group/Employer City of Springfield *Group ID: 10001700 *Subgroup ID or Name:_____ *Class:_____

*** Coverage:**

☐ Dental Coverage

Type of Application

☐ **New Enrollment or Rehire**
Effective Date: _____

☐ **Open Enrollment**

☐ **COBRA**
COBRA (not for current employees)

COBRA Qualifying Events:

☐ Divorce ☐ End of employment
☐ Reduction in hours ☐ Loss of dependent child status
☐ Other _____ Event Date:_____

Changes

☐ **Address Change**

☐ **Name Change**
Effective Date:_____
New Name:_____
Old Name:_____

☐ **Terminate Dependent(s) -** List Dependent(s) being terminated in dependent section, date and reason.
Termination Date:_____
Reason:_____

☐ **Add Members(s) -** List Members(s) to add in member section and qualifying event date*.
Newborn Birth Date:_____
Adoption Date:_____
Marriage Date:_____
(marriage certificate required with enrollment)
Domestic Partnership Affadavit
Date: _____
Only if applicable to your plan **(Domestic Partner Affadavit required with enrollment)**

Court Appointed Guardian
Date:_____
Loss of Group Coverage
Date:_____
(CCC required with enrollment)
Returned to Full-Time Student Status
Date: _____

Oregon Registered Domestic Partner
Date:_____
Only if applicable to your plan
(registered domestic partnership certificate required with enrollment)

*Member adds require a qualifying event date unless added during open enrollment.

Please complete this form and sign on the back. Please type or print legibly in ink. Thank you!

* Employee First Name	M.I.	* Last	* Birth date	* Date of Employment mm/dd/yy	* Employee Social Security #

* Employee Mailing Address	* City	* State	* Zip	Home Phone Number
				( )

* Relationship code: SP=Spouse, DP=Domestic Partner, RDP=Oregon Registered Domestic Partner

* Name First	M.I.	* Last	* Birth date	* Gender	* Relationship	Is this dependent a full-time college student?	If yes, school name
					Self		
					☐ Spouse ☐ DP ☐ RDP		
					Child		
					Child		
					Child		
					☐ Child ☐ Ward		

Other Insurance (Coordination of Benefits)

Will employee or any dependents have **other** insurance?	☐ Dental	☐ No Other Dental Insurance	☐ Medical	☐ No Other Medical Insurance

OVER ⇨⇨⇨

* Enrollment will be delayed if fields noted in red or with an asterisk are not filled out.

ODS Enrollment Application

It is VERY important that the employee sign and date below. Thank you!

Covered Dependent Children Definition

An unmarried child is eligible for coverage if he/she meets the dependent eligibility requirements of the employees plan. See your Member Handbook for details.

The following are eligible dependent children:

-Your natural child
-Your step-child or adopted child
-Children placed with you for adoption
-Newborns born to a covered dependent, for whom you are financially responsible (legal guardianship is required for coverage after the first 31 days)
-Children related by blood or marriage for whom you are the legal guardian (You will need to attach a signed court order showing legal guardianship)
-Your domestic partner's natural child or adopted child (if applicable to your employer plan)
-Your Registered domestic partner's natural child or adopted child (if applicable to your employer plan)

Please read and sign below.

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.* Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports dental records, or hospital records (including nursing records and progress notes).

This acknowledgement does not apply to obtaining information regarding HIV/AIDS, Psychotherapy Notes, Alcohol/Drug and Genetic Testing. A separate authorization will be used for information related to these health conditions.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available by calling the Privacy Office at 503-243-4492.

I certify that the information provided on this form is true and correct to the best of my knowledge. I acknowledge that my enrollment form will be delayed if all the red fields are not filled out entirely.

REQUIRED

* X _____ * Date: _____

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

☐ **Enrollment**
☐ **Change**

MANLEY SERVICES
A PacificSource Company

Phone (541) 485-7488 ◆ (800) 422-7038
www.manleyplan.com

Please return this completed form to your benefits office.

EMPLOYEE INFORMATION

Employer Name: City of Springfield, Oregon			
Employee Name:	SSN*:	Date of Birth:	
Mailing Address:	City:	State:	Zip:
Home Phone:	Work Phone:		
E-mail Address:	Manley ID: (if known)		

DEPENDENT INFORMATION

Dependent information is only required for enrollment in certain plans. Please see your plan administrator to determine whether or not this information is needed for your plan.

Dependent	Last Name	First Name	Middle Initial	Social Security Number*	Date of Birth
Spouse					
Child					
Child					
Child					
Child					
Child					

* Per Internal Revenue Service (IRS) requirements, Social Security numbers are needed for participants and dependents age 44 and older. For details about this regulation, visit the Centers for Medicare and Medicaid Services (CMS) Web site at www.cms.hhs.gov/MandatoryInsRep.

I hereby certify the above information to be correct and true to the best of my knowledge and that the children or dependents for whom I will be claiming dependent expenses either reside with me in a parent-child relationship or are legally dependent on me for their support.

Signature _____ Date _____

Employee: Please return the original to your employer and retain a copy for your records.
Employer: Please forward a copy to Manley Services, unless you will submit a spreadsheet electronically.

EMPLOYER HR USE ONLY:

Employee's Effective Date of Coverage/Change: _____ **Total HRA Contribution**: $_____

Division/Class: _____ **Qualifying Event:** _____

Issue new Benny Card and waive the fee? Y ___ N ___

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